

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015067

STATE FILE NO. 2 3253
Registration District No. _____ Primary Registration District No. _____

FILED APR 20 1959

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS 3225 Montgomery	
Length of stay in 1b 5 mo.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Last Hannagan		4. DATE OF DEATH Month 3 Day 30 Year 59	
5. SEX male o	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12-1878
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Municipal	
11. BIRTHPLACE (City and state or country) Mo. o		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James F. Hannagan		13b. MOTHER'S MAIDEN NAME Elizabeth	
14. NAME OF HUSBAND OR WIFE Agnes Craden Hannagan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. J. Jines 3632 a McRee		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphocytic Leukemia			INTERVAL BETWEEN ONSET AND DEATH 5 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) 204.0 DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal Bronchopneumonia - 2 weeks.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 10-28-58, to 3-30-59 and last saw her alive on 3-30-59 Death occurred at 6:50 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John W. Beckham, M.D. o		22b. ADDRESS 5800 Grand	
22c. DATE SIGNED 3/31/59			
23a. BURIAL, CREMATION, REINTERMENT Burial		23b. DATE 4-2-59	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Missouri	
24. FUNERAL DIRECTOR Thomas J. Finan 1519 S. Grand		25. DATE RECD. BY LOCAL REG. APR 1 '59	
26. REGISTRAR'S SIGNATURE Earl Smith. M.D. G.P.			

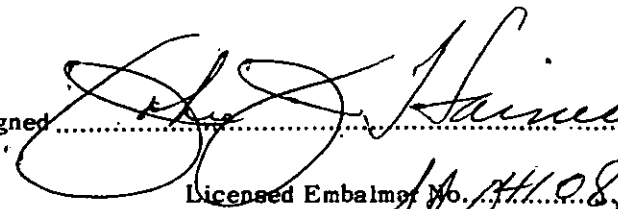
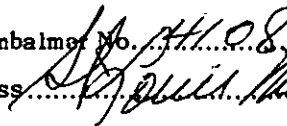
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed 
Licensed Embalmer No. 44108
P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.